Arizona State Board of Pharmacy
1700 W. Washington, Suite 250
Telephone (602) 771-2727 Fax (602) 771-2749
www.azpharmacy.gov

NOTICE AND AGENDA OF A REGULAR MEETING OF THE ARIZONA STATE BOARD OF PHARMACY

Pursuant to A.R.S, § 38-431.02, notice is hereby given to the members of the Arizona State Board of Pharmacy (Board) and to the general public that the Board will hold a Regular meeting open to the public on:

January 28 and January 29, 2009 at 9:00 A.M.
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

One or more members of the Board may participate in the meeting by telephone.

Title 2 of the Americans with Disability Act (ADA) prohibits the Board from discriminating on the basis of disability in its public meetings. Persons with a disability may request a reasonable accommodation by contacting Cheryl Frush, Deputy Director at (602-771-2727). Requests should be made as early as possible to allow time to arrange the accommodation.

During the course of the meeting, the Board, upon a majority vote of a quorum of the members, may hold an executive session for the purposes of obtaining legal advice from the Board's attorney on any matter listed on the agenda pursuant to A.R.S. § 38-431.03 (A) (3) and may hold an executive session on agenda items 9, 10, and 14 for the purpose of discussion or consideration of confidential material pursuant to A.R.S. § 38-431. 03 (A) (2). The executive session will be held immediately after the vote and will not be open to the public.

The agenda is subject to change up to 24 hours prior to the meeting. The Board President reserves the right to change the order of the items on the agenda, except for matters set for a specific time.

AGENDA

The Agenda for the meeting is as follows:

1. **Call to Order – President, Zina Berry, PharmD**

2. **Declaration of Conflicts of Interest**

3. **Discussion and Approval of Minutes**
   Regular Meeting – November 12 and 13, 2008

ITEMS FOR BOARD REVIEW,DISCUSSION, AND LEGAL ACTION

4. **Nomination and Election of Officers – A.R.S. 32-1903 (A)**

5. **Requests/Applications for Permits & Licenses**
   (See Schedule "A" – a detailed listing of Requests/Applications for Permits & Licenses is posted with the agenda at the Board Office)

6. **Special Requests**
   (See Schedule "B" – a detailed listing of special requests is posted with the agenda at the Board Office)

7. **License Applications Requiring Board Review**
   (See Schedule "C" – a detailed listing of license applications requiring board review is posted with the agenda at the Board Office)

8. **Reports**
   - A. **Executive Director Report**
     1. Budget
     2. Newsletter
     3. Introduction of Interns
   - B. **Deputy Director Report**
     1. Report on Inspections since November Meeting
   - C. **Pharmacists Assisting Pharmacists of Arizona Report (PAPA)**
     1. Report on PAPA participants since November Meeting

9. **Conferences**
   (See Schedule "D" – a detailed listing of conferences is posted with the agenda in the Board Office)

10. **Complaint Review – Consideration of Complaints on Schedule "E" and Consideration of Consumer Complaint Committee Recommendations**
    (See Schedule "E" – a detailed listing of complaints is posted with the agenda in the Board Office)

11. **Pharmacy Technician Trainee Requests for Approval to Reapply for Licensure**
    (See Schedule "F" – a detailed listing of pharmacy technician trainee requests is posted with the agenda in the Board Office)

12. **Proposed Rules**
    (See Schedule "G" – a detailed listing of proposed rules is posted with the Agenda in the Board Office)

13. **Five-Year Review of Rules – Article 11**
    A. Minimum Standards for Pharmacy Technicians and Pharmacy Technician Trainees

14. **Consent Agreements – Consideration of Proposed Consent Agreements**
(See Schedule "H" – a detailed listing of consent agreements is posted with the agenda in the Board Office)

15. **Continuous Quality Assurance Program Rules** – Discussion and Possible action regarding proposed Continuous Quality Assurance Rules
A. Presentation by Arizona Community Pharmacy Committee
B. Presentation by Arizona Pharmacy Alliance

16. **Attendance at NABP Annual Meeting – Miami, Florida – May 16-19, 2009**
A. Election of Delegate and alternate delegate

17. **Jon Bach** – Discussion and possible action regarding PAPA steering committee's concerns about prescription drug use and possible referral for evaluation per 32-1927.01 (F)

18, **ExCPT Exam Approval Request** – Discussion and possible action regarding request by ICPT for the consideration of Board's refusal to approve an additional technician exam

19. **Walgreen POWER project** – Discussion and possible action regarding Walgreen's request to deviate from R4-23-1104 (4) which would include remote technician data entry based on experimental and technological advances.

20. **Approval of Exams**
A. NAPLEX B. MPJE C. FPGEEC D. PTCB

21. **Approval of Colleges and Schools of Pharmacy**

22. **Technician Check Technician** – Discussion regarding possible revision to statutes and rules to provide for Certified Technicians to check the work of another technician who is responsible for filling unit dose bins within the hospital environment

23. **Howard Olshansky Proposed Consent** – Discussion and possible action regarding complaint and proposed consent agreement

24. **Ivan Lau Proposed Consent** – Discussion and possible action regarding complaint and proposed consent agreement

25. **Pharmacist Administered Immunizations** – Discussion and possible action regarding Board's position on proposed sunrise on Pharmacist Administered Immunizations

26. **Assistant Attorney General's Update on Low Cost Supreme Court Case No. CV-08-0250-PR**

27. **Update on Controlled Substance Prescription Monitoring Program**

28. **Call to the Public**
The Board may make an open call to the public during the meeting, subject to reasonable time, place, and manner restrictions, to allow individuals to address the Board on any issue within its jurisdiction. Pursuant to A.R.S. § 38-431.91 (G), members of the Board are not allowed to discuss or take legal action on matters raised during an open call to the public unless the matters are properly noticed for discussion and legal action. However, the Board may ask staff to review a matter or may ask that a matter be placed on a future agenda.

29. **Discussion of Items to be placed on a future meeting agenda**

30. **Adjournment**

Prepared and Posted 1/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 & 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "A"

	RESIDENT (Arizona) PHARMACY PERMITS	**OWNER**	**PHARMACIST IN CHARGE**
1.	The Guidance Center – Show Low 2500 E. Show Low Lake Road Show Low, AZ 85901	The Guidance Center, Inc.	Bruce Celiz-Hagen
2.	Bashas' United Drug #16 8423 E. McDonald Dr. Scottsdale, AZ 85251	Bashas' Inc.	Not Designated
3.	Bashas' United Drug #47 16605 E. Palisades Fountain Hills, AZ 85268	Bashas' Inc.	Not Designated
4.	Walgreens Pharmacy #11470 25073 W. Southern Ave. Buckeye, AZ 85326	Walgreen Arizona Drug Co.	Ashley Kalchthaler
5	Apothecary Shop of Gilbert 2450 E. Guadalupe Rd. #110 Gilbert, AZ 85234	TAS Holdings (Ownership Change)	Kim McCrodin
6	Apothecary Shop of Deer Valley 23629 N. 20th Dr. #12 Phoenix, AZ 85085	TAS Holdings (Ownership Change)	Jeffrey Karp
7	Apothecary Shop of Phoenix III 1144 E. McDowell Rd. #402 Phoenix, AZ 85085	TAS Holdings (Ownership Change)	John Kohli
8	Apothecary Shop of Scottsdale 9777 N. 91st St. #C-102 Scottsdale, AZ 85258	TAS Holdings (Ownership Change)	Courtney Yee
9	Apothecary Shop of Phoenix I 1701 E. Thomas Rd. Phoenix, AZ 85016	TAS Holdings (Ownership Change)	Jim Rehovsky
10.	Apothecary Shop of Arrowhead 17612 N. 59th Ave. Glendale, AZ 85308	TAS Holdings (Ownership Change)	Keith Gallus
11.	Apothecary Shop of Tucson II 2181 W. Orange Grove Rd. #135 Tucson, AZ 85741	TAS Holdings (Ownership Change)	Crystal Schneider-Hernandez
12.	Apothecary Shop of Tucson I 4512 E. Camp Lowell Dr. Tucson, AZ 85741	TAS Holdings (Ownership Change)	Eric Sredzinski

Prepared and Posted 01/23/2009 CF

SCHEDULE "A" Cont

RESIDENT (Arizona) PHARMACY PERMITS	OWNER	PHARMACIST IN CHARGE
13. Apothecary Shop of Phoenix II 5040 N. 15th Ave. #102 Phoenix, AZ 85015	TAS Holdings (Ownership Change)	Dan Lindell
14. Apothecary Shop of Grayhawk 2021 N. Scottsdale Healthcare Dr., #100 Scottsdale, AZ 85255	TAS Holdings (Ownership Change)	Susan Pasco
15. Apothecary Shop of Chandler 2155 E. Conference Dr. #101 Tempe, AZ 85284	TAS Holdings (Ownership Change)	Jackie Cavanagh
16. Holiday RX, Inc. 303 E. Baseline Rd. #103 Phoenix, AZ 85042	Holiday RX, Inc.	Harvey Morton
17. El Rio Southeast Pharmacy 6920 E. Golf Links Rd. Tucson, AZ 85730	El Rio Santa Cruz Neighborhood Health Center	Tony Felix
18. Valley of the Sun Pharmacy 15600 N. Black Canyon Freeway Suite C 107 Phoenix, AZ 85053	Rxpertise,LLC (Ownership Change)	Valerie Coronado
19. Walgreens Pharmacy #09952 12050 N. Dove Mountain Blvd. Marana, AZ 85658	Walgreen Arizona Drug Co.	Patrick Jerome
20. Desert Sky Pharmacy 6750 W. Thunderbird Rd Building B, Suite 103 Peoria, AZ 85381	Tai Pham	Tai Pham
21. Wilmot Center Pharmacy 6369 E. Tanque Verde #100 Tucson, AZ 85715	Diversified Pharmacy Solutions, LLC (Ownership Change)	Justin Rhoads
22. Express Scripts 4610 E. Cotton Blvd. Phoenix, AZ 85040	ESI Mail Pharmacy Service, Inc.	Not Designated
23. Medica Pharmacy, Inc. 10304 N. Hayden Rd., Ste 7 Scottsdale, AZ 85258 (Tabled at November 2008 Meeting)	Robert George	Sara Alderman

SCHEDULE "A" Cont.

NON -RESIDENT (Out of State) PHARMACY PERMITS	OWNER	PHARMACIST IN CHARGE
1. Costa Mesa Compounding Pharmacy 275 Victoria St. #1F Costa Mesa, CA 92627	Mayank Shah	Mayank Shah
2. CVS Caremark #2921 600 Penn Center Blvd. Pittsburgh, PA 15235	Procare Pharmacy Direct, LLC. (Ownership Change)	Jill Schachte
3. Green Valley Drugs Home Health 1805 Whitney Mesa, #180 Henderson, NV 89014	Scot Silber	Lola Porter
4. Critical Care Systems 14461 Muford Rd, Suite B Tustin, CA 92780	Critical Care Systems, Inc.	Kathryn Barry
5. IVPCare, Inc. 373 Van Ness Ave., Ste 160 Torrance, CA 90501	IVPCare, Inc. (Ownership Change)	Wade Inouye
6. McKesson Specialty Pharmaceuticals, LLC 6410 NE Halsey, Ste. 400 Portland, OR 97213	McKesson Specialty Pharmaceuticals, LLC (Ownership Change)	Anita Dopkosky
7. IVPCare, Inc. 7164 Technology Dr., Ste 100 Frisco, TX 75034	IVPCare, Inc. (Ownership Change)	Thomas Matthews
8. Commcare Pharmacy-FTL, LLC 2817 E. Oakland Park, Blvd, Suite 303 Fort Lauderdale, FL 33306	Commcare Pharmacy-FTL, LLC	Sal Saraniti
9. Palm Beach Pharmaceuticals, Inc. 8409 N. Military Trail, Suite 125 Palm Beach Gardens, FL 32410	Palm Beach Pharmaceuticals, Inc. (Ownership Change)	Agnes Bergeron
10. PETNET Solutions, Inc. 6320 S. Annie Oakley Dr. Las Vegas, NV 89120	PETNET Solutions, Inc.	Michael Bitar
11. Costco Pharmacy #1032/#562 215 Deininger Circle Corona, CA 92880	Costco Wholesale Corporation	Yong Lee
12. RxCo. Pharmacy 550 13th Ave. East West Fargo, ND 58078	John Slama	John Slama

SCHEDULE "A" Cont.

WHOLESALER PERMITS	OWNER	MANAGER
1. Medical Purchasing Solutions, LLC 15021 N. 74th Sr. #300 Scottsdale, AZ 85260 (Full Service – Previously Owners of a Wholesale Business with No Disciplinary Action)	Medical Purchasing Solutions, LLC	Denis McNicholl
2. Apothecary Shop Wholesale 23620 n. 20TH Dr. #12. Phoenix, AZ 85045 (Full Service – Change of Ownership)	TAS HOLDINGS (Change of Ownership)	Sheri Garver
3. Patterson Dental Supply, Inc. 2849 E. Elvira Rd, Suite 101 Tucson, AZ 85756 (Full Service - Holder of other Wholesale Permits in Arizona)	Patterson Dental Supply, Inc.	Joe McGonigal
4 Avnet Inc. 6700 W. Morelos Place Chandler, AZ 85226 (Full Service – Medical Devices Only – Primarily Glucose Monitors)	Avnet Inc.	Maureen Slagle
5. Avnet Inc. 60 S. McKemy Avenue Chandler, AZ 85226 (Full Service – Medical Devices Only – Primarily Glucose Monitors)	Avnet Inc.	Maureen Slagle

Prepared and Posted 01/23/2009 CF

SCHEDULE "A" Cont.

MANUFACTURER PERMITS	OWNER	MANAGER
1. Rx Formulations 5949 E. University Dr. Mesa, AZ 85205	Zion's Rx Formulations	Troy Albright

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 & 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "B"
SPECIAL REQUESTS

1.	Miles Locke	-	Request to terminate probation per Board Order 03-0020-PHR
2.	James Green	-	Request to terminate probation per Board Order 08-0012-PHR (Addendum)
3.	Sri Saravani Subramanian	-	Request to take the NAPLEX exam for the fourth time

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 and 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "C"
LICENSE APPLICATIONS REQUIRING BOARD REVIEW

1.	Thomas Coppola	-	Request to proceed with reciprocity of Pharmacist License (Previous Disciplinary action in New York)
2.	Michael Lenczynski	-	Request to proceed with reciprocity of Pharmacist License (Previous Disciplinary action in Pennsylvania)
3.	Maia Bibler	-	Request to proceed with Pharmacy Technician Trainee licensure (Felony Conviction)
4.	Latosha Gamez	-	Request to proceed with Pharmacy Technician Trainee licensure (Revocation of Certified Nursing Assistant Certificate by Arizona State Board of Nursing
5.	Jim Brown	-	Request to take the full exam in Arizona for licensure as a pharmacist (Pennsylvania Pharmacist license revoked)
6.	Tip Clements	-	Request for approval to renew his Arizona Pharmacist License that was last renewed in 1990. The California Pharmacy Board recently revoked his California license.

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY

January 28 and 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "D"

CONFERENCES

1.	COMPLAINT #3580	-	Al Redford – Pharmacist In Charge – Respondent
2.	COMPLAINT #3587	-	Michael Schember – Pharmacist – Respondent – Incident 1 Joshua Santiago – Pharmacy Technician – Respondent – Incident 1 Robert Waugh – Pharmacist – Respondent – Incident 2 David Feldman – Director of Pharmacy - Witness

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 and 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "E"

COMPLAINT REVIEW - LIST OF COMPLAINTS BEING REVIEWED

Complaint Number	Respondent
3555	Tariq Maio – Pharmacy Technician Trainee
3557	Jeffrey Golden- Pharmacy Technician Trainee
3558	Patient Care Infusion – Permit Holder
3559	Christina Martinez – Pharmacy Technician
3561	H.D. Smith Wholesale Drug Co. – Permit Holder
3562	H.D. Smith Wholesale Drug Co. – Permit Holder
3579	Francis Nebo –Pharmacist
3590	Express Scripts – Permit Holder
3592	Roger Ngo – Pharmacist
3593	Ernest Bristol - Pharmacist
3594	Terri Lyman – Pharmacist Christel Bird – Pharmacist Carmen Sanchez – Pharmacy Technician
3595	Robert Neuman – Pharmacy Technician Trainee
3596	Phillip Giacobbi – Pharmacist
3597	Natalie Reed – Pharmacist
3598	Walgreens Mail Order Pharmacy – Permit Holder
3599	Walgreens Mail Order Pharmacy – Permit Holder
3600	Humana RightSource Pharmacy – Permit Holder
3601	Ishmael Mohammed – Pharmacist
3602	Anndrea Kale – Pharmacist
3603	Rakesh Daram – Pharmacist Pharmacy Technician Trainee – Julia Bucheck
3604	Afsaneh Melatparast
3605	Betty Novack – Pharmacist
3606	Frank Berry – Pharmacist
3607	Marla Armes – Pharmacist
3608	Pam Wolfson – Pharmacist
3609	Hitesh Thakar – Pharmacist
3610	Richard Salasek – Pharmacist
3612	Wendy Dodt – Pharmacist
3613	Candace McElroy – Pharmacy Technician
3614	Darrell Hendershot – Pharmacist
3615	Humana RightSource – Permit Holder
3616	Humana RightSource – Permit Holder
3617	Humana RightSource – Permit Holder
3618	Express Scripts – Permit Holder
3619	Daniel O' Connor – Pharmacist
3620	Karri Bloom – Pharmacist
3621	Howard Pulver – Pharmacist

SCHEDULE "E" (Continued)

COMPLAINT REVIEW - LIST OF COMPLAINTS BEING REVIEWED

Complaint Number	Respondent
3627	Kimberly Funk – Pharmacy Technician
3628	James Miloshoff – Pharmacist
3630	Richard Mullins – Pharmacist
3631	Korman Healthcare – Permit Holder
3632	Joshua Adama – Pharmacy Technician
3633	Destiny Robinson – Pharmacy Technician
3634	Angelina Williams – Pharmacy Technician
3635	Rebecca Marki – Pharmacy Technician
3636	Mark McKee – Pharmacist
3637	Gerwyn Makai – Pharmacist
3611	Humana RightSource –Permit Holder
3629	Nicole Perkins- Pharmacy Technician

Prepared and Posted 01/23/2009 CF

Complaint Number	Complaint Summary
3555 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician trainee had been terminated for the theft of Controlled Substance Medications. The technician was interviewed and would not admit to the theft. The pharmacy determined that they were missing the following: Various strengths of Hydrocodone/APAP (7,307 tablets), Promethazine with Codeine (6, 837 ml), and Carisoprodol 350mg (3,949 tablets). Pharmacy – CVS Pharmacy #9202 Permit # - Y004468 Pharmacy Technician Trainee Involved with the Complaint – Tariq Maio Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court.
3557 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician trainee had been terminated for the theft of Controlled Substance Medications. The technician was interviewed and admitted to the theft of various strengths of Hydrocodone/APAP (18,934 tablets), Tussionex (480 ml), Ambien 12.5 mg (100 tablets), and Carisprodol (1,516 tablets). The technician held a trainee license until 5/5/08 and did not renew his license. He still held an active license when the incident occurred Pharmacy – CVS Pharmacy #9223 Permit # - Y004479 Pharmacy Technician Trainee Involved with the Complaint – Jeffrey Golden Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court.

Complaint Number	Complaint Summary
3558 **Committee Recommendation:** **Full Board Recommendation:**	A nuclear pharmacy service is alleging that another Arizona licensed pharmacy is using radiochemical Iodine 131 for compounding when there are FDA approved Iodine 131 for compounding. The other pharmacy responded that they carry both forms of the product. They indicated that they carry both radiochemical I-131 and radiopharmaceutical USP/FDA approved I-131. The pharmacy stated that both forms are available to the hospitals and clinics with the understanding that both these products originate from the same reactor and that the radio-purity is identical. It is further understood that radiochemical I-131must be manipulated, and prepared, and that this preparation is designed to improve stability and decrease volatility and at no point is the I-131 changed or made more pure irrespective of the distributor or pharmacy. Pharmacy – Patient Care Infusion Permit # - Y002667 Permit Holder Involved with the Complaint – Patient Care Infusion Violation (s) for current complaint – Possibly no violations for complaint
3559 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacy technician signed a consent agreement that required her to sign a 5 year PAPA agreement. The pharmacy technician signed the agreement in March of 2008 and has not signed a PAPA agreement as of December 31, 2008. The pharmacy technician is in violation of her consent agreement. Pharmacy Technician Involved with the Complaint – Christina Martinez Violation (s) for current complaint – A.R.S. 32-1901.01 (C) (16) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following whether occurring in this state or elsewhere: Violating a formal order, terms of probation, a consent agreement, or a stipulation issued or entered into by the Board or its executive director pursuant to this chapter.
3561 **Committee Recommendation:** **Full Board Recommendation:**	A wholesaler self-reported that their company had been disciplined in Illinois and Wisconsin. Illinois sited the wholesaler for purchasing prescription medications from a source that was not licensed in Illinois. The wholesaler submitted evidence that the purchases were made by a former employee in violation of company policy and without the company's knowledge. The wholesaler purchased repackaged Lipitor and some of the medication was counterfeit. Wisconsin took action after receiving a copy of the order from Illinois. Both states reprimanded and fined the wholesaler. Wholesaler – H.D. Smith Wholesale Drug Company Permit # - Y001171 New Ownership as of December 1/2008 – Smith Medical Partners, LLC Permit Holder Involved with the Complaint – H.D. Smith Wholesale Drug Company Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. 32-1901.01 (A) (13) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a permittee, "unethical conduct" means the following whether occurring in this state or elsewhere: Committing an offense in another jurisdiction that if committed in this state would be grounds for discipline.

Complaint Number	Complaint Summary
3562 **Committee Recommendation:** **Full Board Recommendation:**	A wholesaler self-reported that their company had been disciplined in Illinois and Wisconsin. Illinois sited the wholesaler for purchasing prescription medications from a source that was not licensed in Illinois. The wholesaler submitted evidence that the purchases were made by a former employee in violation of company policy and without the company's knowledge. The wholesaler purchased repackaged Lipitor and some of the medication was counterfeit. Wisconsin took action after receiving a copy of the order from Illinois. Both states reprimanded and fined the wholesaler. Wholesaler – H.D. Smith Wholesale Drug Company Permit # - Y001290 Permit Holder Involved with the Complaint – H.D. Smith Wholesale Drug Company Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. 32-1901.01 (A) (13) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a permittee, "unethical conduct" means the following whether occurring in this state or elsewhere: Committing an offense in another jurisdiction that if committed in this state would be grounds for.
3579 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she arrived at the pharmacy at 8:35 P.M. to have a prescription filled and was scolded by the pharmacist stating that he closed at 9:00 P.M. and wanted to go home. The pharmacist did fill the patient's prescription for Cymbalta. The patient stated that he did not talk to her or ask her if she had any questions. The patient stated that she contacted the pharmacy manager and he told her that the pharmacist has the right to fill or not fill her prescription. The pharmacist stated that he filled the patient's prescription and there were insurance issues that kept the pharmacy staff at the pharmacy until 9:01 P.M. The pharmacist stated that he believes that he did counsel the patient but there is no documentation of the counseling. The pharmacy manager stated that he did speak with the patient and apologized but she did not want to hear anything he had to say. Pharmacy – Wal-Mart Pharmacy #10-5124 Permit # - Y003977 Pharmacist in Charge – Jason May Pharmacist Involved with the Complaint – Francis Nebo Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (G) – Using a method approved by the Board or its designee, a pharmacist shall document or assume responsibility to document that oral consultation is or is not provided
3590 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that the print on the prescription label wears off and you cannot read the prescription label. The pharmacy stated that they are testing a new label and expect to have testing complete by the end of December 2008 with implementation to begin in mid-January of 2009. Pharmacy – Express Scripts Mail Order - Phoenix Permit # - Y003708 Pharmacist in Charge – Albert Redford Permit Holder Involved with the Complaint – Express Scripts Mail Order - Phoenix Previous Complaints – Numerous Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3592 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she sent a prescription to her mail order pharmacy for Zantac 150 mg and received Lamictal 150mg.The patient did not take any of the incorrect medication and the patient notified the pharmacy. The pharmacy sent the patient the correct medication. The pharmacy stated that the prescription was entered incorrectly by the technician and the verifying pharmacist did not catch the error. Pharmacy – Walgreens Mail Service Pharmacy Permit # - Y002628 Pharmacist in Charge – Matthew Cook Pharmacist Involved with the Complaint – Roger Ngo Pharmacy Technician Trainee Involved with the Complaint – Carrie Lee Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (10) (b) – A pharmacist shall check prescription order data entry to ensure that the data input: is for the correct drug by verifying the drug name, strength, and dosage form
3593 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that his mother had a heart attack and was hospitalized. The complainant stated that his mother was given prescriptions upon discharge that she presented to the pharmacy. The complainant stated that his mother was not given the Plavix and 8 days later had another stroke and died. The complainant stated that after he found out that his mother had not been taking the medications prescribed he contacted the pharmacy and was told that the medications (Plavix and Levaquin) had been returned to stock. The pharmacy stated that the patient had been issued two prescriptions for Levaquin 500mg and Plavix 75mg upon discharge from the hospital. The same prescriber's office also phoned in two additional new prescriptions for Furosemide 40 mg and Hydrochlorothiazide 12.5 mg to the pharmacy. The patient also had three additional prescriptions refills processed for Hydrochlorothiazide 25mg, Digoxin 0.125 mg, and Gemfibrozil 600mg. All the prescriptions were scanned and entered on 7/11/2008. The complainant's brother stopped by to pick up his mother's prescriptions and he stated that he picked up 4 prescriptions. He stated that another patient's prescriptions were in the bag with his mother's prescriptions and the clerk removed the incorrect prescriptions. He received Hydrochlorothiazide 12.5mg, Hydrochlorothiazide 25 mg, Digoxin 0.125mg, and Gemfibrozil 600mg. The furosemide 40mg, Levaquin 500mg, and Plavix 75 mg were never sold to the complainant's brother. The prescriptions that were not sold were returned to stock by the pharmacy. The complainant filed the complaint because when he contacted the pharmacy after his mother died he was told it was not the pharmacy's responsibility to ensure that the patient picks up all their medications. His concern is that his mother's prescriptions may have been bagged with another patient's since another patient's medications were bagged with her prescriptions. One of the technicians stated that whoever waited on the person had to look in the computer, under the Work Queue Screen, to see how many prescriptions were to be picked up. There was no counseling documentation for the Hydrochlorothiazide 12.5 mg which was a new prescription. The pharmacy reply indicated on their response that counseling was N/A. If the patient was counseled, he may have noted that the new prescriptions were not present. Pharmacy – Walgreens Pharmacy #3913 Permit # - Y001951 Pharmacist in Charge – Ernest Bristol, Jr. Pharmacist in Charge Involved with the Complaint – Ernest Bristol, Jr. Previous Complaints – No Previous Complaints (Continued on next page).

Complaint Number	Complaint Summary
3593 (Continued)	Violation (s) for current complaint – R4-23-610 (A) (1) – The pharmacist in charge shall ensure the communication and compliance of Board directives to the management, other pharmacists, interns, and technicians of the pharmacy. The pharmacist in charge did not ensure that regulations that require counseling and documentation of counseling were complied with by the pharmacy staff. {(R4-23-402 (H) (1), (2), (3) (4)}. The pharmacist in charge did not ensure that staff was verifying that a completed prescription medication is sold only to the correct patient or patient's caregiver. {R4-23-402 (A) (15). When the technician removed the incorrect medications from the patient's bag she did not look to see if the patient had additional prescriptions to be picked up.
3594 **Committee Recommendation:** **Full Board Recommendation:**	A law firm reported to the Board that a patient had died due to a prescription error. The prescription error occurred in 2006 and was just settled with the company. The patient presented a prescription for Morphine ER 15 mg #60 with directions to take one tablet twice daily. The prescription was filled with Morphine ER 60mg #60 with directions to take one tablet twice daily. The prescription was filled on 7/20/2006. On 7/25/2006, the patient called the doctor and told him that her pain medication was not working. The doctor told the patient to increase the dose to 2 tablets twice daily. On 7/25/2006, the patient was found dead in her bed as a result of respiratory depression. The prescription was entered incorrectly by the technician and the error was not caught by the pharmacist verifying the directions or by another pharmacist verifying the product. Pharmacy – Walgreens Pharmacy #6666 Permit # - Y003513 Pharmacist in Charge – Jason Dykstra Pharmacist Involved with the Complaint – Terri Lyman – Verified data entry Pharmacist Involved with the Complaint – Christel Bird – Verified product Pharmacy Technician Involved with the Complaint – Carmen Sanchez Previous Complaints – Terri Lyman – 1. 6/2005- Incorrect dosage alleged by veterinarian – Miscommunication between pharmacist and veterinarian – Conference Christel Bird – 1. 5/2002 – Dispensed duplicate lithium prescriptions resulting in overdose - Conference Violation (s) for current complaint – Both Pharmacists – R4-23-402 (A) (11) – A pharmacist shall make a final accuracy check on the completed prescription medication… Terri Lyman – R4-23-402 (A) (10) – A pharmacist shall ensure that a prescription communicates the prescribers directions precisely.

Complaint Number	Complaint Summary
3595 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician Trainee had been terminated for the theft of Controlled Substance Medications. The technician admitted to the theft. The technician stated that he was stealing the medications for an ex-fiancé who was suffering from cancer pain. The technician floated to various stores within the chain. An audit was conducted by the Compliance Officer at 4 separate stores. It was determined that the following quantities were missing: Oxycodone 5/325 mg (59 tablets), Oxycodone ER 20 mg (13 tablets), Oxycodone IR 30 mg (11 tablets), Oxycodone IR 5 mg (27 tablets), Oxycodone 10/325 mg (4 tablets), Endocet 7.5/325 mg (1 tablet), Hydromorphone 4 mg (1 tablet), Oxycodone IR 15 mg (90 tablets), and Oxycodone 7.5/325 mg (9 tablets). The technician began working for the company on October 16, 2008 and was terminated on October 28, 2008. During the investigation by the pharmacy chain, it was determined that the technician had lied on his employment application stating that he had never been convicted of or awaiting a trial for a felony or misdemeanor. The technician stated that he was not but had been found guilty of assault in 2002. The technician also supplied false information on his technician application. He replied no to the question on the application asking if he had any convictions involving a misdemeanor or felony offense. Pharmacy – Bashas' Pharmacy #100, Bashas' Pharmacy #86, Bashas' Pharmacy #160, Food City #164 Permit # - Y003676, Y002981, Y004260, Y004840 Pharmacy Technician Trainee Involved with the Complaint – Robert Jacob Neuman Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court. A.R.S. 32-1901.01 (C) (13) - – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Knowingly filing with the Board any application, renewal, or other document that contains false or misleading information.

Complaint Number	Complaint Summary
3596 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that the pharmacist entered the days supply incorrectly when he filled her prescriptions and the error was corrected by the pharmacy manager. The complainant stated that the pharmacist refused to fill her Soma prescription that was faxed from the physician's office. The complainant stated that the pharmacist refused to fill her CII prescriptions. The patient was getting Kadian 200mg (2 capsulestwice daily), Fentora 800mcg (1 unit twice daily as needed), Hydromorphone 4mg (2 tablets daily as needed for pain), and Soma 350mg (1 tablet four times daily as needed). The pharmacist indicated that initially he did not feel comfortable filling the CII prescriptions for the patient, but did notice that the patient had the prescriptions filled at another CVS pharmacy. The pharmacist stated that he declined to fill the Soma prescription because it was unclear who the prescribing physician was for the medication and the doctor's office had difficulty in determining who authorized the refill. The pharmacist stated that he refused to fill any further prescriptions for the patient because of the high doses prescribed. The pharmacist stated that he feels that the patient should not be driving under the influence of such high doses of narcotics and she often drives to the pharmacy to pick up her prescriptions. Another pharmacist that works at the store came in on his day off and filled the patient's prescriptions. The Pharmacy Supervisor felt that the pharmacist had not done a thorough job in researching the issue involving the patient's needs, past history, high dosing of these medications and the overall handling of the situation. Pharmacy – CVS Pharmacy #7022 Permit # - Y004945 Pharmacist in Charge – Ezekiel Kesitilwe Pharmacist Involved with the Complaint – Phillip Giacobbi Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations
3597 **Committee Recommendation:** **Full Board Recommendation:**	The complainant, who works in a doctor's office, phoned a prescription to the pharmacy for Darvocet N-100 and became upset when the pharmacist questioned the dose. The complainant stated that the pharmacist was rude and yelled at her that she was going to kill the patient. The pharmacist stated that she received a voicemail prescription for Darvocet N-100 with directions to "Take 1 to 2 tablets every 4 to 6 hours" which would have given the patient 7,800 mg of acetaminophen daily if taken as directed. The pharmacist stated that the dosage exceeded the maximum dose of 4,000 mg of acetaminophen daily and she called the office to check the dosage. The pharmacist stated that the medical assistant, the complainant, became defensive when she questioned the dosage. The medical assistant refused to allow the pharmacist to speak with the doctor. The pharmacist stated that she called and spoke with the doctor the next day and he told the pharmacist that she could add a maximum dosage warning on the label for the patient not to exceed 6 tablets daily. The prescription was never picked up by the patient. Pharmacy – Target Pharmacy #T-2176 Permit # - Y004762 Pharmacist in Charge – Andrew Daniels Pharmacist Involved with the Complaint – Natalie Reed Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3598 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she received a refill of Levothyroxine 112mcg after she had submitted a new prescription for a different strength (Levothyroxine 125mcg). The patient stated that the prescription for Levothyroxine 112mcg was on autofill and she stated that she was told that she was responsible for payment since she had not cancelled the autofill. The pharmacy stated that it is not there policy to modify the dispensing of a medication unless directed by the patient or physician. There was no indication from the patient or physician at the time the new prescription was received to discontinue the previous dose. The pharmacy has credited the patient's copay as a one time courtesy. Pharmacy – Walgreens Mail Order Pharmacy Permit # - Y002628 Pharmacist in Charge – Matt Cook Permit Holder Involved with the Complaint – Walgreens Mail Order Pharmacy Previous Complaints – Numerous Complaints Violation (s) for current complaint – Possible violation – It is not clear if a DUR review is conducted when the prescription is on autofill. If a DUR audit is not conducted by a pharmacist it would be in violation of R4-23-402 (A) (5) (b) – A pharmacist shall verify the legality and pharmaceutical feasibility of dispensing a drug based upon: Incompatibilities with a patient's currently-taken medications.
3599 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he has been shorted three times when he has ordered his prescription of ranitidine from his mail order pharmacy. After the last shortage of 11 tablets, the patient contacted the pharmacy and his request to receive the missing tablets was denied because he did not contact the pharmacy within 30 days of receiving the medication. The Pharmacy stated that their policy is that the patient needs to contact the pharmacy about damaged or shorted medications within 30 days of the ship date. The original request was denied as the pharmacy was contacted 2 months after the ship date. After further correspondence, the pharmacy investigated and determined through a weight test of the package that the order was shorted. Additional medication was then sent to the patient. The pharmacy stated that the automated dispensing machine is tested monthly and did not indicate a shortage on the test counts for ranitidine. The pharmacy believes that the shortage was due to human error in using the cassette and not a mechanical failure. Pharmacy – Walgreens Mail Service Pharmacy Permit # - Y002628 Pharmacist in Charge – Matthew Cook Permit Holder Involved with the Complaint – Walgreens Mail Service Pharmacy Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violations
3600 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he placed an order over the phone with his mail order pharmacy and was sent a medication that he did not order. The complainant stated that he received and was charged for Celebrex when he ordered Celexa. The patient profile showed a history of dispensing both Celexa and Celebrex. The pharmacy provided a copy of the call dialogue and a recording of the call indicating that the patient requested and confirmed the refill request for Celebrex three times. The Celebrex prescription had no refills remaining and the pharmacy contacted the physician. The refill request was approved and the medication was dispensed correctly by the pharmacy. Pharmacy – Humana RightSource Pharmacy- Phoenix Permit # - Y004370 Pharmacist in Charge – Dennis McAllister Permit Holder Involved with the Complaint – Humana RightSource Pharmacy-Phoenix Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3601 **Committee Recommendation:** **Full Board Recommendation:**	The complainant, a certified pharmacy technician, working at a physician's office filed the complaint because she felt that a pharmacist was requesting a medication change for a patient and felt that this activity was out of the scope of practice for a pharmacist. The pharmacist stated that the patient received a prescription for lisinipril 10 mg on 11/4/2008. The patient developed a cough and the doctor's office phoned in a new prescription for Diovan 80mg with directions to take one-half tablet daily which required prior authorization. The pharmacist stated that the patient asked him to contact the doctor to request a generic medication since the generic medication would be cheaper for her than the higher copay for the Diovan. The pharmacist stated that the patient had not been able to tolerate the calcium channel blockers or ace inhibiters in the past. He suggested that the doctor may try Metoprolol ER. The pharmacist also noted the Diovan 80 mg tablets are not scored. The patient obtained samples of Diovan 80 mg from the doctor and no one told her to take one-half of a tablet and she took a whole tablet. The pharmacist believes that the doctor's office was upset when he told them the patient was taking 80mgs of Diovan instead of 40 mgs of Diovan and that her blood pressure was not controlled. The pharmacist believes that this is why the technician filed the complaint Pharmacy – Walgreens Drug #809 Permit # - Y000572 Pharmacist in Charge – Ishmael Mohammed Pharmacist Involved with the Complaint – Ishmael Mohammed Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations
3602 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he felt that the pharmacy may have misfilled his blood pressure medications because his blood pressure was higher than normal when he visited his doctor. The doctor suggested that he go to the pharmacy and speak to the pharmacist because he told the doctor that the amlodipine tablets that he received at his previous pharmacy were different in appearance than the tablets he received at his new pharmacy. The complainant felt that the pharmacy would not admit that they made an error, so he filed a complainant instead of contacting the pharmacy. The Compliance Officer called the complainant from the pharmacy where he verified that the patient had received the correct tablets for all of his medications and had received a different generic brand for his Metoprolol 100mg than he had received before from the other pharmacy. No error was made in the filling of the phoned in prescriptions Pharmacy – Osco #961 Permit # - Y004563 Pharmacist in Charge – Andrea Kale Pharmacist Involved with the Complaint – Andrea Kale Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3603 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that her prescription for Morphine ER was filled with Morphine IR resulting in her being hospitalized. The pharmacy received a prescription for the patient written as Morphine Sulfate 30mg tablets with directions to take one tablet orally every 12 hours. The quantity on the prescription was verified by the Pharmacist in Charge prior to the patient arriving to pick up the prescription. The pharmacist did not verify the dosage form. The pharmacist on duty stated that he filled the prescription when the patient arrived. The technician entered the prescription and the pharmacist filled the prescription. The technician indicated that the pharmacist was always the one who told the technicians what drug to enter for a controlled substance prescription. The pharmacist stated that he misread or misinterpreted the quantity change as an approval of some kind to use the Immediate Release form. The complainant refused counseling. The complainant had the prescription filled on 7/25/2008 and did not notify the pharmacy until 12/2/2008 of the error. Pharmacy – CVS Pharmacy #5937 Permit # - Y004704 Pharmacist in Charge – Elizabeth Crowe Pharmacist Involved with the Complaint – Rakesh Daram Pharmacy Technician Trainee Involved with the Complaint – Julia Bucheck Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (10) (b) – A pharmacist shall check prescription order data entry to ensure that the data input: is for the correct drug by verifying the drug name, strength, and dosage form R4-23-402 (A) (10) (c) – A pharmacist shall check prescription order data entry to ensure that the data input: communicates the prescriber's directions precisely by verifying dose, dosage form, route of administration, dosing frequency, and quantiy. R4-23-402 (11) - A pharmacist shall make a final accuracy check on the prescription medication and manually initial the finished label…
3604 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that a pharmacist engaged in off-duty misconduct involving implied threats concerning use of protected information. The pharmacist stated that her interaction with the complainant occurred when she acted as an intermediary involving a contract dispute between her husband and Dex (the complainant's employer). The pharmacist stated that at no time has she ever expressly said or intimated that she has access to the complainant's personal medical information. The computer system in place at Fry's Pharmacy #673 is not a linked system that allows access to all of the Fry's pharmacies. A review of the patient profiles at Fry's Pharmacy #673 where the pharmacist works did not show any information on the complainant. The complainant indicated that evidence of off duty misconduct exists, however no such evidence has been provided for review. Pharmacy – Fry's Pharmacy #673 Permit # - Y004357 Pharmacist in Charge – Roger Rahaeuser Pharmacist Involved with the Complaint – Afsaneh Melatparast Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3605 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he received 100% DMSO instead of 50% DMSO for treatment of interstitial cystitis. Complainant reported severe bleeding and pain at the time of instillation and intermittent bleeding, pain, and frequency of urination following the instillation. The pharmacist in charge stated that the physician's representative called in a DMSO cocktail and the pharmacist sought clarification. The cocktail was picked up by the patient on September 4, 2008. The physician's representative called back on September 5, 2008 and told the pharmacist that 15 ml was not the correct quantity. The pharmacist offered to compound the additional quantity. The representative indicated that she wanted 50 ml of DMSO. Per the pharmacist in charge, the pharmacist discussed it with the representative and dispensed 50ml of DMSO reagent.(100%). The Compliance Officer spoke with the representative at the physician's office. The representative indicated that she had called the pharmacy and had requested a DMSO cocktail and had referenced Rimso 50 when speaking with the pharmacist. The product dispensed to the patient was DMSO reagent 50 ml repackaged from the laboratory and labeled as Dimethylsufoxide reagent liq. #50. There was no documentation of counseling and no written information was provided to the patient. Pharmacy – Apothecary Shop of Scottsdale Permit # - Y003387 Pharmacist in Charge – Courtney Yee Pharmacist Involved with the Complaint – Betty Novack Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (7) – A pharmacist shall interpret the prescription order, which includes exercising professional judgment in determining whether to dispense a particular prescription R4-23-402 (G) – Using a method approved by the Board or its designee, a pharmacist shall document or assume responsibility to document that oral consultation is or is not provided R4-23-402 (H) (4) – Oral consultation shall include: Providing oral information regarding special instructions and written information regarding side effects, procedure for missed doses, or storage requirements.

Complaint Number	Complaint Summary
3606 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she ordered four prescriptions on line early because she was going to be out of town. The complainant stated that she contacted the insurance company and they stated that they would do an override so that she could receive her prescriptions early. The complainant alleges that the pharmacist refused to fill her prescription and then made her wait for her prescription after the store manager became involved. The pharmacist stated that the complainant arrived at his store and was told that the insurance company had not authorized one of the refills. The pharmacy technician had told the patient the previous day that the insurance company had not authorized one of the refills and they would contact the insurance company again. The complainant accused the pharmacy of not contacting the insurance company. The pharmacist stated that he was present when the technician contacted the insurance company and was told that they would phone the pharmacy back with a response. The pharmacist stated that he ran the prescription through the system and the claim was approved. The pharmacist stated that during his conversation with the patient he may have pointed out to the patient that the pharmacist has the final say in filling a controlled substance prescription early and not the insurance company. The pharmacist stated that the patient misunderstood and sought out a store manager who came and asked him how long it would take to fill the prescription and he told him 15 minutes. He filled the prescription and the patient left. Pharmacy – Wal-Mart Pharmacy #1381 Permit # - Y002322 Pharmacist in Charge – Frank Berry Pharmacist Involved with the Complaint – Frank Berry Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations
3607 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she presented a prescription for Fentanyl 50mcg patches to the pharmacy. The complainant stated that the prescription was filled with Fentanyl 100 mcg patches. The complainant stated that her doctor gave her a prescription for Fentanyl 75mcg to wean her back down to 50mccg. The patient stated that she was hospitalized as a result of the overdose. The pharmacist entered the prescription into the computer incorrectly and dispensed the medication incorrectly. The pharmacist stated that she counseled from the sticker label on the back of the prescription causing her not to catch the error. The pharmacist indicated that she felt that the inconsistent labor and floater pharmacists at the store may have contributed to the error. Pharmacy – Fry's Pharmacy #612 Permit # - Y003270 Pharmacist in Charge – Marla Armes Pharmacist Involved with the Complaint – Marla Armes Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (10) (b) – A pharmacist shall check prescription order data entry to ensure that the data input: is for the correct drug by verifying the drug name, strength, and dosage form R4-23-402 (A) (11) – A pharmacist shall make a final accuracy check on the prescription medication and manually initial the finished label…

Complaint Number	Complaint Summary
3608 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that the pharmacist would not fill his prescription for Percocet 7.5 mg because she only had 50 tablets in stock and the prescription was for 120 tablets. The complainant stated that the pharmacist gave his wife a list of the Percocet prescriptions that he had filled at other pharmacies and told his wife that he was taking too much. The complainant stated that he took the prescription back to the pharmacy several days later and the pharmacist refused to fill his prescription because it was a couple of days early. The pharmacist stated that according to the insurance records the patient had received a 30 day supply of Percocet 7.5/325 on 11/8/08 from another pharmacy, a prescription for 10 tablets of Percocet 5/325 on 11/12/08 from another pharmacy, a prescription for 30 tablets of Percocet 7.5/325 on 11/14/2008 from another pharmacy, a prescription for 30 tablets of Percocet 7.5/325 on 11/25/2008 from her pharmacy, and presented a new prescription for 120 tablets of Percocet on 11/28/2008 to her pharmacy which was not filled due to a shortage of medication and a rejection by the insurance company. The pharmacist stated that she did not have enough medication to fill the prescription and relayed to the patient's wife that they did not have enough medication to fill the prescription. The patient's wife was given a list of prescription transactions that the patient had received. The patient's wife was given the date the prescription was filled, the drug name, and the address of the pharmacy. The pharmacist gave this medication list to the patient's wife since she was acting as his agent by picking up his prescriptions. The pharmacist stated that when the prescription was presented a few days later the pharmacy refused to refill the prescription because it was too soon to fill. The patient wanted to pay cash for the prescription, but the pharmacist denied the request. The records indicate that the patient had paid cash for the prescriptions filled on 11/10/2008, 11/14/2008, and 11/25/2008 when the insurance rejected the prescriptions as being too soon to fill. Pharmacy – Costco #691 Permit # - Y003646 Pharmacist in Charge – Winifred Wong Pharmacist Involved with the Complaint – Pam Wolfson Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations
3609 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that the pharmacy would not dispense his blood pressure medication to him because he did not have a verifiable address. The pharmacy manager stated that when the complainant came to the "Out Window" to pick up his prescription the technician asked the complainant to verify his address. The pharmacy manager stated that the prescriptions were phoned in by the physician and they asked the patient to verify his address to ensure that they were giving the medications to the correct patient. The pharmacist stated that the complainant refused to verify the old address and refused to give any new address. As a result of the refusal by the patient to verify his address, the pharmacy refused to dispense the medications to the complainant. Pharmacy – Walgreens #3726 Permit # - Y002831 Pharmacist in Charge – Hitesh Thakar Pharmacist Involved with the Complaint – Hitesh Thakar Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violations

Complaint Number	Complaint Summary
3610 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that his physician issued a prescription for the wrong strength of Hydromorphone and was told by the pharmacist to call the physician. The complainant stated that when he returned to the pharmacy to pick up the correct prescription, the pharmacist accused him of selling the prescription on the streets and he felt that was unprofessional conduct. The pharmacist stated that because of his experience in getting a call back from the hospital, he felt the fastest way to get the situation resolved was for the patient to go back to the hospital and get a new prescription. A phone call was then received from the physician, and an emergency prescription was faxed to the pharmacy with a hard copy to be mailed to the pharmacy. The physician asked that the first prescription be returned to the pharmacy and returned to him. When the patient returned to the pharmacy he asked why he had to surrender the first prescription. The patient was told that the doctor wanted the prescription back, and the pharmacist added that he did not know the patient and the drug was highly used on the street and the original prescription could be altered. The pharmacist did indicate that he was aware of the information that could be changed on CII prescription, but the prescription was issued from the hospital and he had issues receiving a call back from the hospital in a timely fashion. Pharmacy – Osco Drug #955 Permit # - Y004557 Pharmacist in Charge – Richard Salasek Pharmacist Involved with the Complaint – Richard Salasek Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violation
3612 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that the pharmacy would not fill her Sertaline early because she had knocked over her tea and was only able to salvage four tablets of her prescription. The pharmacist stated that the complainant's prescription for Sertaline was entered on November 20 2008 and payment was rejected by the insurance company because the prescription was filled on November 2, 2008. The patient became upset because the pharmacist would not fill her prescription and came into the store and yelled at everyone. The pharmacist stated that the patient should have had 10 tablets left and did not tell her that she had spilled tea on her tablets. The pharmacist stated that she told the patient that she would contact the doctor on Monday for authorization to fill her prescription early and get authorization to get an insurance override. The patient left the store without the medication. Pharmacy – Walgreens #5888 Permit # - Y003328 Pharmacist in Charge – Wendy Dodt Pharmacist Involved with the Complaint – Wendy Dodt Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violation

Complaint Number	Complaint Summary
3613 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician had been terminated for the theft of Controlled Substance Medications. The technician admitted to the theft. The technician admitted to stealing approximately 10 bottles of Promethazine with Codeine. The store calculated that from 5/1/2007 through 12/10/2008 that they experienced a loss of approximately 20 pints of Promethazine with Codeine. The technician stated that she thought that they could make some money by selling the medication. Pharmacy – Fry's Pharmacy #87 Permit # - Y003962 Pharmacy Technician Involved with the Complaint – Candace McElroy Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court.
3614 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she received Oxycodone ER 20 mg instead of Oxycodone ER 10mg. The complainant stated that when she questioned the pharmacist about the difference in color he told her that it was a different manufacturer. The patient called back after several days and the Pharmacist in Charge confirmed that she had the wrong strength. The patient was told to contact her physician since she had taken several tablets of the wrong strength. The pharmacist that filled the prescription stated that he does not recall the incident. There is also no documentation of counseling. Pharmacy – CVS Pharmacy #33 Permit # - Y004054 Pharmacist in Charge – Ezekiel Baker Pharmacist Involved with the Complaint – Darrell Rodney Hendershot Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (10) (b) – A pharmacist shall check prescription order data entry to ensure that the data input: is for the correct drug by verifying the drug name, strength, and dosage form R4-23-402 (A) (11) – A pharmacist shall make a final accuracy check on the completed prescription medication… R4-23-402 (G) – Using a method approved by the Board or its designee, a pharmacist shall document or assume responsibility to document that oral consultation is or is not provided R4-23-402 (H) – A pharmacist shall document or assume responsibility to document the name, initials, or identification code of the pharmacist who did or did not provide oral consultation.

Complaint Number	Complaint Summary
3615 **Committee Recommendation:** **Full Board Recommendation:**	The complainant provided documentation of letters sent to a mail order pharmacy concerning the following areas: the automated telephone system, unauthorized charges and reimbursement, dispensing of medications not ordered, medication not sent in a timely manner, and medication sent to the wrong patient. A response was received from the Pharmacist-in-Charge and provides information of the functions of the automated dispensing systems, patient copay responsibilities, prescription processing and dispensing. No documentation was found that the member was dispensed another member's medication. The patient's entire pharmacy record was searched in an attempt to determine any pharmacy deficiencies. It has been determined that the patient has an outstanding credit of $808.00 and the pharmacy will be forwarding a check in that amount to the complainant. Pharmacy – Humana RightSource - Phoenix Permit # - Y004370 Pharmacist in Charge – Dennis McAllister Permit Holder Involved with the Complaint – Humana RightSource Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violations
3616 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that thirteen days after he ordered medications through an online system he received a letter stating that he had a balance and the pharmacy was unable to get in touch with him. He contacted the pharmacy so they would release his prescription but the pharmacy would not expedite his delivery even though he would be out of medication in two days. The pharmacy stated that they hold all orders where the copay is greater than $250 and an automated call is placed to the member in case they want to cancel the order due to the high copay. A follow-up letter is sent to the member when no response is received from the automated call. When the member called the pharmacy on October 6, 2008 he gave the pharmacy his new address and phone number. The phone call and letter were sent out based on the old patient information resulting in the delayed shipping. The order shipped out the day after the pharmacy received the patient's updated contact information and authorization to ship. Pharmacy – Humana RightSource - Phoenix Permit # - Y004370 Pharmacist in Charge – Dennis McAllister Permit Holder Involved with the Complaint – Humana RightSource Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violations
3617 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he requested prescriptions not be dispensed if the price was greater than $30.00 and he received a prescription where he was charged $223.41. The complainant stated that he was not connected to a pharmacist when requested and he received broken tablets in one shipment. The pharmacy stated that the complainant made his request to a call center representative and also on a sticky note attached to the order to call him if the charge would be greater than $30.00. His request was missed and the prescriptions were filled and shipped. The pharmacy credited the patient's account and the medication was returned. A review of the call center logs show the complainant requested a specific pharmacist and was advised that the specific pharmacist could not be contacted directly, and the representative was not sure the complainant would get that pharmacist when the call was transferred. The pharmacy stated that the broken tablets were replaced after the complainant contacted the pharmacy. Pharmacy – Humana RightSource – Phoenix Permit # - Y004370 Pharmacist in Charge – Dennis McAllister Permit Holder Involved with the Complaint – Humana RightSource Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violation

Complaint Number	Complaint Summary
3618 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he did not order Plavix from a mail order pharmacy and the pharmacy would not allow him to return the medication. The complainant stated that the pharmacy also would not close his account. The pharmacy received a faxed prescription from the prescriber on September 23, 2008 however the prescriber also faxed a prescription to CVS on the same day. The prescription was placed on hold at the mail order pharmacy as it rejected as "refill too soon" due to the dispensing by CVS. A letter was sent to the patient informing him the medication would be automatically dispensed on October 13, 2008 unless the patient instructed the pharmacy otherwise. The pharmacist-in-charge stated that the pharmacy did not receive any instructions from the patient, so the medication was sent to the patient. The patient contacted the pharmacy on October 16, 2008 saying he had not ordered the medication and the representative explained to the patient that he was responsible for the copay as the pharmacy did have a legitimated prescription. The pharmacy has since offered to issue a credit to the patient if the medication is returned. Pharmacy – Express Scripts Permit # - Y003618 Pharmacist in Charge – Hector Pacheco Permit Holder Involved with the Complaint – Express Scripts -Albuquerque Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violations
3619 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that he received Amlodipine 5mg tablets instead of Amlodipine/Benazepril 5/10 mg capsules on a transferred prescription. The complainant did not take any of the incorrect medication. The pharmacist transferred, entered, and verified the prescription. He stated that since the error has occurred, he has increased technician support hours, slowed down at verification, and taken 2 hours of CE on how to reduce medication errors. Pharmacy – CVS Pharmacy #89 Permit # - Y004063 Pharmacist in Charge – Daniel O'Connor Pharmacist Involved with the Complaint – Daniel O'Connor Previous Complaints – No Previous Complaints Violation (s) for current complaint – R4-23-402 (A) (10) (b) – A pharmacist shall check prescription order data entry to ensure that the data input: is for the correct drug by verifying the drug name, strength, and dosage form R4-23-402 (A) (11) – A pharmacist shall make a final accuracy check on the completed prescription medication…
3620 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that she had four prescriptions filled at the pharmacy for her son. She stated that the prescription for Bactrim DS generic was short 1 tablet and his prescription for Percocet 7.5/325 mg was over by 10 tablets. The pharmacist stated that when the situation was brought to her attention the errors were corrected. The pharmacist stated that the Bactrim DS generic is counted by an automated dispensing machine. The pharmacist stated that she has tested the automated dispensing machine and there have been no other shortages. The pharmacist stated that the technician miscounted the Percocet prescription. Pharmacy – Walgreens #6736 Permit # - Y001746 Pharmacist in Charge – Karri Bloom Pharmacist Involved with the Complaint – Karri Bloom Previous Complaints – No Previous Complaints Violation (s) for current complaint – No Violation

Complaint Number	Complaint Summary
3621 **Committee Recommendation:** **Full Board Recommendation:**	A district office reported that a pharmacist was terminated because of gross misconduct. The pharmacist was terminated for theft of merchandise, misappropriation of gift card use, and authorized prescription refills on numerous prescriptions without authorizations. Compliance Officer Ed Hunter has visited numerous doctors and they have indicated that they did not authorize the refills or authorize the quantities and number of refills on the prescriptions. Pharmacy – Wal-Mart # 10-1532 Pharmacist in Charge – Howard Pulver Pharmacist Involved with the Complaint – Howard Pulver Previous Complaints – No Previous Complaints Violation (s) for current complaint A.R.S. 32-1901.01 (B) (2) and (11) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacist, pharmacy intern, or graduate intern, "unprofessional conduct" means following, whether occurring in this state or elsewhere: (2) Violating any federal or state law, rule or regulation relating to the manufacture of distribution of drugs and devices or the practice of pharmacy. (11) Knowingly dispensing a drug without a valid prescription order as required pursuant to section 32-1968, subsection A. A.R.S. 32-1968 A. - A prescription-only drug shall be dispensed only under one of the following conditions: 1. By a medical practitioner in conformance with section 32-1921. 2. On a written prescription order. 3. On an oral prescription order that is reduced promptly to writing and filed by the pharmacist 4. By renewing any written or oral prescription order if a renewal is authorized by the prescriber either in the original prescription order or by an oral order that is reduced promptly to writing and filed by the pharmacist.
3627 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacy owner reported that they had terminated a technician due to the fact that the technician was arrested on illegal drug charges and probation violations. The technician was found guilty of dangerous drug possession and possession of drug paraphernalia. Pharmacy – Spring Valley Pharmacy Permit # - Y005003 Pharmacist in Charge – Sharon Richardson Pharmacy Technician Involved with the Complaint – Kimberly Funk Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. 32-1901.01 (C) (6) – In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following whether occurring in this state or elsewhere: Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude or any drug related offense. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

Complaint Number	Complaint Summary
3628 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a pharmacist was terminated because he admitted to the theft of controlled substances from the pharmacy without a prescription and to forging prescriptions for controlled medications. The pharmacist admitted to the theft of Hydrocodone products and forging prescriptions for Tussionex, Soma, and Alprazolam. The Compliance Officer is conducting an audit and survey of possible prescription forgeries. The pharmacist has signed a PAPA contract but wants to return to Indiana. PAPA is not willing to monitor the pharmacist in Indiana. The pharmacist does not have an Indiana pharmacist license and only has an expired Intern license in Indiana. Pharmacy – Walgreens #01272 Permit # - Y000132 Pharmacist Involved with the Complaint – James Miloshoff Previous Complaints – No Previous Complaints Violation (s) for current complaint - A.R.S. 32-1901.01 (B) (2) and (11) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacist, pharmacy intern, or graduate intern, "unprofessional conduct" means following, whether occurring in this state or elsewhere: (2) Violating any federal or state law, rule or regulation relating to the manufacture of distribution of drugs and devices or the practice of pharmacy. (11) Knowingly dispensing a drug without a valid prescription order as required pursuant to section 32-1968, subsection A. A.R.S. 32-1968 A. - A prescription-only drug shall be dispensed only under one of the following conditions: 1. By a medical practitioner in conformance with section 32-1921. 2. On a written prescription order. 3. On an oral prescription order that is reduced promptly to writing and filed by the pharmacist 4. By renewing any written or oral prescription order if a renewal is authorized by the prescriber either in the original prescription order or by an oral order that is reduced promptly to writing and filed by the pharmacist.
3630 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacist signed a consent agreement that required him to sign a 5 year PAPA agreement. The pharmacist signed the agreement in September of 2008 and has not signed a PAPA agreement as of December 31, 2008. The pharmacist is in violation of his consent agreement. Pharmacist Involved with the Complaint – Richard Mullins Violation (s) for current complaint – A.R.S. 32-1901.01 (B) (20) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacist, pharmacy intern, or graduate intern "unprofessional conduct" means the following whether occurring in this state or elsewhere: Violating a formal order, terms of probation, a consent agreement, or a stipulation issued or entered into by the Board or its executive director pursuant to this chapter.
3631 **Committee Recommendation:** **Full Board Recommendation:**	A permit holder signed two consent agreements that required him to pay a civil penalty. The permit holder signed the agreement in March of 2008 and was to pay his civil penalty by September 30, 2008. As of December 31, 2008, the civil penalty has not been paid. The permit holder is in violation of his consent agreements. Permit Holder Involved with the Complaint – Korman Helathcare Violation (s) for current complaint – A.R.S. 32-1901.01 (A) (19) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a permittee, "unethical conduct" means the following whether occurring in this state or elsewhere: Violating a formal order, terms of probation, a consent agreement, or a stipulation issued or entered into by the Board or its executive director pursuant to this chapter.

Complaint Number	Complaint Summary
3632 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician had been terminated for the theft of Controlled Substance Medications. The technician admitted to the theft. The technician stated that he was stealing various strengths of Hydrocodone/APAP because he had a lower back problem. The technician admitted to taking at least 10 to 12 tablets daily. An audit conducted by Wal-Mart indicated that they were missing the following quantities: Hydrocodone/APAP 10/325mg (818 tablets), Hydrocodone/APAP 10/500mg (1642 tablets), Hydrocodone/APAP 10/650mg (576 tablets), Hydrocodone/APAP 7.5/325mg (100 tablets), and Hydrocodone/APAP (492 tablets). The technician was licensed at the time of the theft and termination. The technician did not renew his license and the license expired 10/31/2008. Pharmacy – Wal-Mart Pharmacy Permit # - Y002647 Pharmacy Technician Involved with the Complaint – Joshua Adams Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court.
3633 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacy technician self- reported that she was convicted of a felony. The felony was a result of sexual conduct with a minor. Pharmacy Technician Involved with the Complaint – Destiny Robinson A.R.S. 32-1901.01 (C) (6) – In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following whether occurring in this state or elsewhere: Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude or any drug related offense. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.
3634 **Committee Recommendation:** **Full Board Recommendation:**	The court reported that a pharmacy technician trainee that was convicted of a felony. The felony was a result of attempted theft of a credit card or obtaining a credit card by fraudulent means. The court has suspended the defendant's license while she is on probation. The defendant is on probation for two years. Pharmacy Technician Involved with the Complaint – Angelina Williams A.R.S. 32-1901.01 (C) (6) – In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following whether occurring in this state or elsewhere: Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude or any drug related offense. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

Complaint Number	Complaint Summary
3635 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a Pharmacy Technician had been terminated for the theft of Controlled Substance Medications. The technician was observed via security camera consuming controlled substances while working/being on duty in the pharmacy. The pharmacy technician denied the allegations and listed that she consumed Mylanta and wrote on her statement that she resigns. The store conducted an audit of the medications being consumed by the technician. The store determined that there was a shortage of 110 ml of Tussionex Suspension and a shortage of 100 ml of Guafenesin with Codeine. Pharmacy – Fry's Pharmacy #87 Permit # - Y003962 Pharmacy Technician Involved with the Complaint – Rebecca Marki Previous Complaints – No Previous Complaints Violation (s) for current complaint – A.R.S. § 32-1968 (A) (6) – A prescription-only drug shall be dispensed only under one of the following conditions: by refilling any written, electronically transmitted, or oral prescription order if a refill is authorized by the prescriber either in the original prescription order, by an electronically transmitted refill order that is documented promptly and filed by the pharmacist or by an oral refill order that is documented promptly by the pharmacist and filed by the pharmacist. A.R.S. 32-1901.01 (C) (8) – In this chapter, unless the context otherwise requires for the purpose of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following, whether occurring in this state or elsewhere: Violating a federal or state law or administrative rule relating to marijuana, prescription, prescription –only drugs, narcotics, dangerous drugs, controlled substances, or precursor chemicals when determined by the board or by conviction in a federal or state court.
3636 **Committee Recommendation:** **Full Board Recommendation:**	A Pharmacy District Office reported that a pharmacist was terminated due to an admission of theft of Oxycontin for personal use via fraudulent prescriptions. The company is conducting an ongoing investigation to determine the exact loss. The pharmacist has contacted PAPA and signed a PAPA contract. Pharmacy – Walgreens #3087 Permit # - Y001136 Pharmacist in Charge – Mark McKee Pharmacist Involved with the Complaint – Mark McKee Previous Complaints – No Previous Complaints Violation (s) for current complaint - A.R.S. 32-1901.01 (B) (2) and (11) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacist, pharmacy intern, or graduate intern, "unprofessional conduct" means following, whether occurring in this state or elsewhere: (2) Violating any federal or state law, rule or regulation relating to the manufacture of distribution of drugs and devices or the practice of pharmacy. (11) Knowingly dispensing a drug without a valid prescription order as required pursuant to section 32-1968, subsection A. A.R.S. 32-1968 A. - A prescription-only drug shall be dispensed only under one of the following conditions: 1. By a medical practitioner in conformance with section 32-1921. 2. On a written prescription order. 3. On an oral prescription order that is reduced promptly to writing and filed by the pharmacist 4. By renewing any written or oral prescription order if a renewal is authorized by the prescriber either in the original prescription order or by an oral order that is reduced promptly to writing and filed by the pharmacist.

Complaint Number	Complaint Summary
3637 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacist self-reported that he had experimented with methamphetamine and was hospitalized due to side effects. The hospital also notified the Board. The pharmacist was arrested and charged with possession of drug paraphernalia. The pharmacy was told to contact PAPA. The pharmacist spoke with Julian Pickens at PAPA and was told to contact Valley Hope because the pharmacist believed that he did not have a drug problem. Valley Hope recently contacted Lisa Yates and told her that the pharmacist had been admitted for inpatient treatment. The pharmacist has not contacted PAPA to let them know that he was admitted. Pharmacist Involved with the Complaint – Gerwyn Makai Previous Complaints – No Previous Complaints Violation (s) for current complaint - A.R.S. 32-1901.01 (B) (2) and (8) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacist, pharmacy intern, or graduate intern, "unprofessional conduct" means following, whether occurring in this state or elsewhere: (2) Violating any federal or state law, rule or regulation relating to the manufacture of distribution of drugs and devices or the practice of pharmacy. (8) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude or any drug related offense. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

Complaint Number	Complaint Summary
3611 **Committee Recommendation:** **Full Board Recommendation:**	The complainant stated that when his wife received her package from the mail Order pharmacy she received only 90 tablets of Alprazolatm 0.5 mg and should have received 270 tablets. A weight comparison of the original shipping weight and a dummy order with the Alprazolam shorted was not concluvise as the shipping weight rounds to 0.1 pounds. An audit of the Alprazolam 0.5 mg on December 30, 2008 indicated that the pharmacy had an overage of 66 tablets and again was not conclusive evidence to determine an actual short count. The pharmacy contacted the patient's physician and requested a new prescription to authorize dispensing an additional 180 tablets. The patient and physician chose to have the prescription filled locally. Pharmacy – Humana RightSource – Phoenix Permit # - Y004370 Pharmacist in Charge – Dennis McAllister Permit Holder Involved with the Complaint – Humana RightSource Previous Complaints – Numerous Complaints Violation (s) for current complaint – No Violation
3629 **Committee Recommendation:** **Full Board Recommendation:**	A pharmacy technician signed a consent agreement that required her to sign a 5 year PAPA agreement. The pharmacy technician signed the agreement in May of 2008 and has not signed a PAPA agreement as of December 31, 2008. The pharmacy technician is in violation of her consent agreement. Pharmacy Technician Involved with the Complaint – Nicole Perkins Violation (s) for current complaint – A.R.S. 32-1901.01 (C) (16) - In this chapter, unless the context otherwise requires, for the purposes of disciplining a pharmacy technician or pharmacy technician trainee, "unprofessional conduct" means the following whether occurring in this state or elsewhere: Violating a formal order, terms of probation, a consent agreement, or a stipulation issued or entered into by the Board or its executive director pursuant to this chapter.

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 & 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "F"

Pharmacy Technician Trainee Requests to reapply for licensure

1. **Robyn Smith**
2. **Barbara McElfresh**
3. **Mona Schalen**
4. **Adriana Padilla**
5. **Bruce Mendelson**
6. **Mary Romero**
7. **Heather Brown**
8. **Jennifer Jaase**
9. **Sedina Muslim**
10. **Marie Francis**
11. **Christine Blenman**
12. **Lanette Bloomer**
13. **Christine Hardyway**
14. **Phyllis Skurda**
15. **Kimberly Way**
16. **Stephanie Wyble-Jones**
17. **Diana Arnov**
18. **Tricia Jefferson**
19. **Greg Helton**
20. **Gina McCullough**
21. **Shirley White**
22. **Tara Bond**
23. **Cinthia Aala**
24. **Olga Boystova**
25. **Sandra Cameron**
26. **Briea Banzhof**
27. **Rosa Fuentes**
28. **Malynn Helton**
29. **Keisha Neal**
30. **John Wilkes**
31. **Belinda LaRosa**
32. **Sakeerah Kennedy**

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 and 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "G"
PROPOSED RULES

PROPOSED RULES

1.	R4-23-422, 423	-	Drug Therapy Management (Approval of Notice of Final Rulemaking and Economic Impact Statement)

Prepared and Posted 01/23/2009 CF

BEFORE THE ARIZONA STATE BOARD OF PHARMACY
January 28 and 29, 2009
Arizona State Board of Pharmacy Office
1700 W. Washington, Third Floor Board Room
Phoenix, AZ 85007

SCHEDULE "H"
CONSENTS

1.	Patricia Stucks	-	08-0027-PHR
2.	Brian Schreckengost	-	09-0006-PHR
3.	Lameck Nyakweba	-	09-0009-PHR
4.	Scott Anderson	-	09-0016-PHR
5.	Gloria Martinez-Howell	-	09-0018-PHR
6.	Daniel May	-	09-0019-PHR
7.	Hyman Abramchick	-	09-0010-PHR
8.	Arleen Kaizer	-	08-0051-PHR

Prepared and Posted 01/23/2009 CF